ExamOne® www.MyExamOne.com
A Quest Diagnostics Company

Ticket: 0032018516 LX3868348

LAB CODE 5046

Z

INSURANCE COMPANY INFORMATION

INSURANCE COMPANY FULL NAME: PRINCIPAL FINANCIAL DES MOINES IA

HOME OFFICE CITY: GUARDIAN PITTS FIELD STATE: MO

REFERENCE / POLICY / MEMBER / CONTRACT NUMBER:

AGENT LAST NAME: FISCHMAN AGENT FIRST NAME: ARI TELEMUS

AGENT CODE: AGENT PHONE NUMBER: STATE: ZIP CODE:

AGENT EMAIL ADDRESS: @

6 ☑ INDIVIDUAL ☑ LIFE ☐ HEALTH / MEDICAL
7 ☐ GROUP ☐ DISABILITY ☐ LONG-TERM CARE

AMOUNT OF INSURANCE APPLIED FOR [redacted] K

PROPOSED INSURED INFORMATION

LAST NAME: FISHMAN

FIRST NAME: RYAN M.I.: J GENDER: ☒ Male ☐ Female

DATE OF BIRTH: SOCIAL SECURITY NUMBER: [redacted]

STREET ADDRESS: [redacted]

EMAIL ADDRESS: @

URINE TEMPERATURE: CURRENT MENSES: How many hours since you last ate/drank? HEIGHT: WEIGHT:

TEST REQUEST
☐ A1C ☐ CBC ☐ CDT
☐ Full Drug ☐ Hepatitis
☐ Microalbumin ☐ PSA
Other

In the past 5 years have you had a moving violation, or has your driver's license been restricted, suspended or revoked?
☐ Yes ☑ No

[redacted]

3. If no, how long since you last used

EXAMINING C ExamOne 700
☐ ExamOn Robert Skalski
BRANCH NUM San Diego, CA
800-489-9528

Prior to allowing [redacted] to be collected, I, the Proposed Insured, have read and understand the Notice and Consent that appears on the Important Applicant Information Brochure which includes information about HIV/AIDS. I voluntarily consent to the testing of my blood, urine and/or oral fluid specimen(s), and to the use and disclosure of the test results and other information about me (including but not limited to medical information) as described on the Important Applicant Information Brochure. If HIV testing is requested by the insurer, I authorize HIV testing on my specimen(s). If a blood specimen(s) was drawn, I did voluntarily consent to the withdrawal of blood from me by needle or lancet. I further acknowledge receipt of the Important Applicant Information Brochure.

I, the Proposed Insured, verify that the enclosed contents of this/these vial(s) is/are indeed my blood, urine and/or oral fluid specimen(s). I verify that my oral fluid specimen or urine specimen, if collected, was placed into a vial which was sealed with tamper-evident tape that I have signed. I acknowledge that I have read my information as captured on this ID form and verify that it is accurate.

NO ATTEMPT BY THE PROPOSED INSURED TO MODIFY OR AMEND THIS FORM WILL CHANGE ITS TERMS OR IN ANY WAY BE BINDING UPON THE INSURANCE COMPANY OR ANY OF ITS AGENTS OR CONTRACTORS.

X _____ Signature of **Proposed Insured / Legal Guardian**

3 (Month) 17 (Day) 25 (Year) 10 (Hour) 32 (Minute) ☒ AM ☐ PM

I verify that the enclosed specimen(s) was/were properly collected. I further verify that this/these specimen(s) is/are in fact the specimen(s) collected from the Proposed Insured named on this ID form and that the proper barcode label has been placed by me on the specimen vial(s) for the Proposed Insured named on this ID form.

X _____

BL 001789
5046 Z

[redacted]

Principal®

Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Medical Questionnaire

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Print full name of Proposed Insured	Date of Birth (Month/Day/Year)
RYAN J FISHMAN	6.24.88

[redacted]

4. In the last five years:
   a. have you had any medical tests (excluding tests for HIV (AIDS Virus), hospitalization, illness or injury not provided in response to a previous question? ..... ☐ ☒
   b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? ..... ☒ ☐

[redacted]

DETAILS TO QUESTIONS 1-8

For "yes" answers to questions 1-6 include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address. (If additional space needed, attach a separate page that is completed, witnessed, signed, and dated)

Quest. #	
4a	Lastin Chiopractic exams 1-2 x/month @ LEVINE CLINIC NORTHWESTERN HWY, SOUTHFIELD FARMINGTON HILLS MI

[redacted]

[redacted]

Medical Questionnaire, continued

[redacted]

☐ None

Phone Number

Zip

I have read the statements and answers recorded above; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Signature of Proposed Insured	Date	Signature of Witness/Title
X	3.17.21	X

PHYSICAL MEASUREMENTS RECORDED BY EXAMINER

[redacted]

Name of agent soliciting application: ANI FISHMAN (FISCHMAN)

Examination made at: ☐ Examiner's Office ☒ Applicant's Home ☐ Other

Examiner (print name) ROBERT SKALSKI

Exam Company Name ExamOne 700 'ara Med.

Exam Company Address Robert Skalski
San Diego, CA
800-489-9528

Signature of Examiner X

Send exam to Home Office only.

[redacted]